



010 01718-1Q-0087

**Department of Veterans Affairs
Office of Inspector General**

**Memorandum to the File
Case Closure**

**Alleged Mismanagement of Healthcare Resources Contracts and
Conflict of Interest (Self-Referrals) by Contract Physicians
(2012-01978-1Q-0087)**

The VA Office of Inspector General (OIG) Administrative Investigations Division initiated an investigation into allegations that Mr. [REDACTED], former Medical Center Director, [REDACTED], failed to take action on allegations that healthcare resources contracts were not being monitored properly; the contracting officer's representative (COR) lacked training and experience for the delegated responsibilities; the COR certified invoices without verifying contract compliance; and contract physicians engaged in conflicts of interest. To assess these allegations, we interviewed Dr. [REDACTED], Medical Center Chief of Staff (COS). Based on this interview, we referred the allegations back to VA OIG Hotline and recommended that they forward them to the VA [REDACTED] Network (VISN [REDACTED]) for their inquiry as a case referral.

On March 28, 2012, we interviewed Dr. [REDACTED] to clarify the allegations. He told us that immediately after filing his complaint with VA OIG Hotline in February 2012, he also reported them to Mr. [REDACTED], VISN [REDACTED]. He said that he told Mr. [REDACTED] that he also filed a complaint with OIG and that it no longer mattered that his identity as the complainant be kept confidential.

Dr. [REDACTED] told us that soon after being appointed as COS in October [REDACTED], he discovered numerous irregularities involving physicians' salaries, retention incentives, abuse of authority, conflicts of interest, and mismanagement of healthcare resources contracts. He said that he immediately reported what he discovered to Mr. [REDACTED] and that over a period of several months and after making numerous requests, Mr. [REDACTED] refused to take any action or allow him (Dr. [REDACTED]) to take corrective action.

Dr. [REDACTED] told us that since reporting his concerns to VISN [REDACTED] officials, Mr. [REDACTED] was reassigned to another position pending either administrative action or his retirement. He said that VISN [REDACTED] officials dispatched human resources and contracting teams to the medical center to review the salary, retention incentives, and contract issues. He further said that he began a recruitment campaign in an attempt to hire VA physicians to replace some of the contract physicians. In addition, he said that he addressed the mismanagement of the healthcare resources contracts to ensure that the contracts were properly monitored, to include the proper verification of contract compliance before invoices were certified for payment. Moreover, he said that he removed one contract physician who made self-referrals and that he arranged for Regional Counsel to provide ethics and conflict of interest training to all of the contract physicians. He said that the training was videotaped so that others who did not attend the live training session would be able to receive the training by watching the video.

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Dr. [REDACTED] said that he was very pleased with VISN [REDACTED]'s response. Based on VISN [REDACTED] officials already addressing the allegations, we told Dr. [REDACTED] and he agreed, that OIG would not continue with their investigation but instead, we would allow the VISN [REDACTED] officials to complete theirs. On March 28, 2012, we referred the allegations to the VA OIG Hotline and recommended they forward them to VISN [REDACTED] as a case referral. We therefore took no further action concerning this matter.

These allegations are being closed without a formal report or memorandum.

Prepared [REDACTED] 4/3/2012
Date

Approved: [REDACTED] 4/3/12
Date